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VIA FACSIMILE COPY TO (718) 613-2540 AND ECF

June 27, 2012

Honorable Nicholas G. Garaufis
United States District Court
Eastern District of New York
225 Cadman Plaza East
Brooklyn, New York 11201

Re: United States v. Conrad Ianelli, *et al.*
Criminal Docket No. 12-264 (NGG)

Dear Judge Garaufis:

Our client John Squitieri is recovering from a recent operation on his knee. According to his doctor, he "is not to place any unnecessary pressure or weight on his knee outside of prescribed PT nor to travel far by car" (*see* attached letter from doctor and operation notes). Based upon this, we request that his appearance for the July 12th status conference be waived.

Thank you for your consideration on this matter.

If you have any questions, please contact me at (845) 634-9500.

Very truly yours,

KENNETH GRIBETZ, ESQ.

Enclosure

cc: AUSA Amanda Hector (via ECF)
Co-Defendants' Counsel (via ECF)

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June 25, 2012

To Whom It May Concern:

Patient John Squitieri has been under my care since April 5th, 2012 for a opinion about a right knee heterotopic ossification.

Until October 1st, 2012, the patient is not to place any unnecessary pressure or weight on his knee outside of prescribed PT nor to travel far by car until further notice. This is due to the patient having a total knee revision on May 30th, 2012 along with the removal of a heterotopic ossification and follow up radiation treatment, both of which causes prolonged recuperation.

Thank you in advanced for your cooperation with this matter. Please feel free to contact me with any questions or concerns regarding this matter.

Very Truly Yours,

Asit Shah, MD

ENGLEWOOD HOSPITAL and MEDICAL CENTER
350 Engle Street
Englewood, NJ 07631

REPORT OF OPERATION

NAME: SQUITIERI, JOHN MRN: 010020826
SURGEON: Asit Shah, MD DATE: 05/30/2012

PT LOCATION: ACCOUNT NO: 701413825
HOSP SERV: ORT

DATE OF OPERATION: 05/30/2012

PREOPERATIVE DIAGNOSES: Stiffness right total knee, heterotopic ossification, status post total knee replacement.

POSTOPERATIVE DIAGNOSES: Stiffness right total knee, heterotopic ossification, status post total knee replacement.

PROCEDURE PERFORMED: Removal of heterotopic ossification, revision right total knee replacement.

ATTENDING SURGEON: Asit Shah, MD

ASSISTANT: Erin Moreau, PAC, Richard L Salzer, MD

PLASTIC SURGEON: Norberto Soto, MD

IMPLANTS USED: Optitrack exact type posterior stabilized size 3 right femoral component, 32 mm diameter patellar component and a tibial insert size 3, 9 mm thickness.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room. Consent and laterality were established. Site and consent were checked and marked. The patient was prepped and draped in standard surgical fashion.

A midline incision was made over the previous incision. A medial parapatellar incision was made across the previous suture lines. Hemostasis was achieved. Synovium and fluid were evacuated and sent for cultures and pathology showing no acute inflammation.

Proximally the incision was extended and under the quadriceps mechanism significant amount of heterotopic ossification was visualized. This was removed from the anterior cortex of the femur with an osteotome. The heterotopic ossification had infiltrated the vastus intermedius and some of the muscle had to be removed with the heterotopic ossification. Two significant amounts of heterotopic ossification and scar tissue was removed and then attention was turned to the gutters and the gutters were cleared of any remaining scar tissue that was present.

The medial parapatellar slide was performed and soft tissues released off the medial side. He had very limited range of motion from 0 to 30 and, as continued release of this posterior medial corner was performed, increased motion was obtained and the tibia was subluxed anteriorly. The insert was removed to allow clearance to allow for more release along the posterior side, as well as the posterior aspect of the PCL.

The tibial component was found to be fairly secure and stable to the bone. The

femoral component appeared to be in a few degrees of flexion and there was some lucency over the anterior cortex of the femur, which was easily removed from the remainder, without sacrificing much of the bone on the femoral side. The cement was left behind. It had de-bonded at the cement/metal interface. Cement was evacuated as well.

At this point, once the femoral component was removed and the tibial insert was removed, more scar tissue was removed from the gutters as well. The wound was jet lavaged at this point and I felt that a femoral trial of the same size, which was sized appropriately in the AP and ML direction, was replaced in anatomic position and a 9 mm insert was trialed. The patient had excellent stability in ML and soft tissue balance, flexion-extension balance. Gap was performed and showed excellent stability with the 9 mm insert.

I did not feel that he had adequate bony support and I did not feel the patient needed a revision replacement with a constrained liner in order to conserve bone along the box. At this point I recemented in a size 3 right posterior stabilized exact type knee in the appropriate position, after an adequate debridement and jet lavage was performed along the femoral component and the size 9 insert was secured into place.

The patient was placed through a range of motion. He appeared to have some radiolucency along the border of the patella, which was removed and resurfaced and a 32 mm diameter patella was placed. Excellent patellofemoral tracking was obtained with a minimal amount of lateral release.

At this point the wound was irrigated again and Dr. Soto performed a full plastic closure on the wound. The patient tolerated the procedure well and was transferred to recovery stable.

Asit Shah, MD

Dict: Fri Jun 22 12:05:02 2012
Trans: Fri Jun 22 15:24:17 2012
Job#: 77634352

CC: Asit Shah, MD ; Richard L Salzer, MD; Norberto Soto, MD; Erin Moreau, PAC
Authenticated by Asit Shah, MD On 06/23/2012 07:28:21 AM